2012 Behavioral Health Integration Public Stakeholder Process
Evaluation (Data) Workgroup Report
Last Updated: 08/17/2012

WORKGROUP CHARGES

The Data and Evaluation Workgroup was created as a part of the process of selecting a finance and integration model for Medicaid-funded behavioral health care in Maryland. The workgroup was given two charges: (1) determine what data should be considered when making a recommendation and (2) identify performance measures to evaluate the model.

The workgroup was led by an Executive Sponsor, Tricia Roddy, Director of Planning in the Office of Healthcare Financing. The workgroup did not have formal membership; instead, all stakeholders were invited and encouraged to participate. The workgroup met six times between May and August 2012. Participants represented a wide array of organizations. Throughout the process, verbal and written comments were accepted. The workgroup staff did its best to incorporate submitted comments into this report. The findings of this report represent the key areas discussed during the workgroup meetings. They may not, however, represent the views of every participant.

The Executive Sponsor and the Behavioral Health Integration Steering Committee would like to thank everyone who attended or otherwise contributed to the workgroup's efforts.

OVERVIEW OF MEETINGS

May 9th
- Discussed workgroup objectives, expectations, and schedule
- Presented a proposed databook showing enrollment and utilization of somatic and behavioral health services across care settings, coverage groups and diagnosis groups.

June 6th
- Guest presentation by Michael Abrams of the Hilltop Institute on Latent Class Analysis

June 19th
- Presented revised databook populated with Fiscal Year (FY) 2011 data

July 11th
- Presented expanded databook populated with FY 2008-2011 data
- Presented fact sheet on HealthChoice, Primary Adult Care (PAC) and Fee-for-service (FFS) coverage
- Presented expenditure data for substance abuse services, by individual procedure code
- Presented outline of existing clinical outcome measures under HealthChoice, the ADAA grant system, and MHA's ASO contract

July 25th
- Presented inpatient stays for top 25 diagnoses by program and diagnosis group for FY 2008-2011
- Presented proposed template for organizing performance measures

August 8th
- Collected comments on performance measures template and general comments on models

WORKGROUP CHARGE 1: WHAT DATA IS RELEVANT TO MODEL SELECTION?

The first charge of the workgroup was to identify what data should be considered when selecting the model. To fulfill this charge the workgroup produced a series of datasets, which were discussed during the meetings. The main document was a series of databooks showing enrollment and utilization of somatic and behavioral health services, organized by coverage group, diagnosis group, and service setting. Other documents included data tables showing the top inpatient diagnoses by coverage and diagnosis group, and data tables showing expenditures on substance abuse treatment by individual procedure code.

Databooks

At the initial meeting, the Executive Sponsor proposed generating a databook that would display enrollment and utilization data on the current behavioral health system through a series of databooks, and presented a template to the workgroup. Workgroup participants were supportive of the databook approach, although comments were submitted on how to improve the template. The workgroup staff revised the template and presented populated databooks in subsequent meetings.

The revised databook provided four years of Medicaid enrollment and utilization data across the following Medicaid service delivery systems: HealthChoice, Primary Adult Care (PAC), HealthChoice/PAC, and Fee-for-Service. The HealthChoice bucket contained enrollment and service utilization data for individuals with some span of enrollment in HealthChoice (and not PAC) during the calendar year. The PAC bucket contained enrollment and service utilization data for individuals with some span of enrollment in PAC (and not HealthChoice) during the calendar year. The HealthChoice/PAC bucket included enrollment and utilization data for the subset of individuals that transitioned between HealthChoice and PAC during the calendar year. The Fee-for-Service bucket contained individuals with some span of FFS coverage during the calendar year. Within these coverage buckets, data was grouped into four diagnosis groups: Mental Health, Substance Abuse, Dual-Diagnosis ("Both"), and Neither. Service data was grouped into seven service settings: Inpatient, Outpatient, Physician/Professional, Pharmacy, Special Services, Home Health and Long Term Care. Within these settings, services were categorized into Substance abuse, Mental Health, and Somatic services. By organizing the data in such a way, workgroup participants were able to comparatively analyze enrollment and utilization of somatic and behavioral health services across coverage and diagnosis groups. The final version of the databooks can be found in Appendix 1.

Top 25 Inpatient Diagnoses

Workgroup participants requested data showing the number of inpatient Admissions for the Top 25 Diagnosis Codes. Data was organized in similar formats as the databooks, allowing for comparisons across coverage groups, diagnosis groups, demographics, and over multiple years. This can be found in Appendix 2.

Substance Abuse Expenditures

At the request of the workgroup, the Executive Sponsor also provided expenditures on outpatient substance abuse treatment services, organized by procedure code. Figures reflected those in the Joint Chairmen's Report on Outpatient Substance Abuse Expenditures released in June 2012. This can be found in Appendix 3.

Medicaid Fact Sheet

Noting the complexity of the databook and the programmatic differences between HealthChoice, PAC and Fee-for-service, workgroup participants requested a fact sheet on the programs. This can be found in Appendix 4.

Data Analysis and Commentary

After the datasets were presented, both workgroup participants and Executive Sponsor offered analysis and commentary on the data. The following represent key ideas and takeaways from these discussions; this should not be viewed as an exhaustive list and may not represent the view of every workgroup member.

How important is it to have all family members served by the same managed care organization (MCO)?

The data reveal that a large number of HealthChoice enrollees who have a mental illness or substance abuse diagnosis are enrolled under the Medicaid Family and Children eligibility category. This means that a large percentage of the population is part of a household with other members receiving Medicaid benefits. Under Model 3 – in which qualified individuals are disenrolled from a 'standard' MCO and enrolled in a behavioral health MCO – a household may have individuals enrolled in multiple MCOs, which could complicate access to care.

How does the prevalence of FFS enrollees inform model discussion?

The data show that a substantial portion of the Medicaid population with a behavioral health diagnosis receives somatic care through unmanaged fee-for-service coverage. In FY 2011, 22 percent of the population with a mental health diagnosis received somatic care through a fee-for-service coverage, while ten per cent of the population with a substance abuse diagnosis received somatic and substance treatment through a fee-for-service coverage. Historically, individuals in fee-for-service coverage tend to be high users of somatic and behavioral health services. The large majority of them also tend to be dually eligible for Medicare and Medicaid due to the fact that current HealthChoice rules disenroll individuals who are eligible for Medicare, 65 or older, or enrolled in a nursing home for more than 30 days.

How does the presence of a sizable FFS population in the diagnosis groups inform the model selection?

Unless the current rules for the HealthChoice program change, individuals who age-out, become dually eligible for Medicaid and Medicare services, or are admitted to a nursing home for more than 30 days would enter an unmanaged FFS system. Alternatively, an Administrative Services Organization could be hired to help manage behavioral health services when individuals enter the FFS system. The same would apply to Model 3 unless eligibility included dual-eligibles, individuals in nursing homes, and those over age 65. On the other hand, the Administrative Services Organization under Model 2 could manage the care across the HealthChoice, PAC, and FFS programs. Addressing the needs of the FFS population may require policy makers to answer a larger question of whether dual-eligibles may be enrolled in managed care organizations.

What proportion of hospital services is somatic versus mental health?

Examining the population aged 19 to 64 with a behavioral health diagnosis (156,052 individuals), there is a significant difference between the utilization of somatic services and mental health services in hospital settings. 19 percent (29,299 individuals) utilized somatic services in a hospital inpatient setting, while only five percent (8,230 individuals) utilized mental health services in a hospital inpatient setting. 61 percent (95,250 individuals) utilized somatic services in a hospital outpatient setting, while only 13 percent (20,030 individuals) utilized mental health services in a hospital outpatient setting. These numbers demonstrate the complexities of coordinating somatic and behavioral health services. Under Model 2, the HealthChoice program would be responsible for the vast majority of the hospital services for individuals with a behavioral health diagnosis. The Administrative Services Organization is responsible for mental health services, and in order to promote integration under this model, different incentives may need to be considered. Model 1 has one set of incentives, and Model 2 has a different set of incentives. It would be helpful to consider both and determine which set of incentives are most appropriate under the model and whether or not the set of incentives better promotes integration.

Significant growth in enrollees with a behavioral health diagnosis

Between 2008 and 2011, the number of Medicaid enrollees with a behavioral health diagnosis has increased substantially, from roughly 200,000 to 286,000 individuals. The number of SUD-diagnosed and dual-diagnosed (individuals with both a mental health and substance abuse diagnosis) enrollees doubled over that period. The Medicaid Expansion under the Affordable Care Act will allow PAC enrollees to receive full Medicaid benefits and will increase overall enrollment starting in January 2014. But this begs the question: from an administrative and operational standpoint, the model selected must be able to handle a sizeable growth in the number served.

Population with a BH Diagnosis - 2008 to 2011

	Dual Diagnosis		MHD Only		SUD Only	
	Number	**Growth**	**MHD Only**	**Growth**	**SUD Only**	**Growth**
2011	36,987	12.91%	223,940	10.26%	24,902	26.00%
2010	32,759	35.67%	203,107	11.19%	19,764	41.05%
2009	24,146	17.72%	182,674	10.56%	14,012	11.98%
2008	20,511	-	165,225	-	12,513	-

Excess inpatient costs

Using the counts of inpatient stays for the top six somatic diagnoses, a workgroup participant presented an analysis that compared inpatient costs for substance abuse and mental health diagnosis groups to inpatient costs for the "neither" group. Looking at the population of HealthChoice adults, the workgroup participant found an estimated $86.4 million in what was described as excess inpatient costs. The participant also provided the relative risk of inpatient admission for this population and argued that the best integration model was Model 1. These analyses highlight the importance of choosing a model that minimizes the incidence of avoidable hospitalizations. See Appendix 5.

Payment Reform

A Workgroup participant noted that in order to significantly improve integration payment reforms should be considered. Global capitation may be achieved only under Model 1. Under Model 2, other payment reforms may be considered, such as shared savings for 2a and financial incentives tied to performance targets for 2b. Selecting a Model should consider what payment reforms may be built into the Model.

Comments suggesting additional data sources

In addition to analyzing presented data, workgroup participants suggested that additional data sources be considered, including:

- National Outcomes Measurement System (NOMS) data currently collected by MHA and ADAA
- National 2005 Medicaid data; specifically comparing data from states that have implemented the models currently under consideration
- Behavioral health data from the Kaiser Commission
- More detailed information on mental health and substance abuse diagnoses

The Executive Sponsor noted that time constraints prevented the workgroup from presenting these data, and noted that some these sources would likely be considered in phase three of integration.

Comments regarding data use in an integrated system

Workgroup participants also provided comments regarding the collection and reporting of data in the administration of an integrated system. These included:

- If Model 2 is selected, the ASO should have the ability to capture data on individuals within the model. In addition, once that data is collected it should be transferred, presented, and analyzed by an independent entity.
- Agencies should not be required to duplicate data reporting systems. To streamline this reporting it is suggested that the Department inform agencies of specific data specifications that are required to be built into their systems.
- Data collection should be standardized across administrative entities
- A participant noted the herculean effort involved in getting substance abuse cost data from the MCOs. On the other hand, another participant noted that the MCOs have demonstrated their ability to perform the necessary data collection and monitoring associated with the PAC expansion. This experience could be built upon to ensure MCO accountability for the delivery of behavioral health services. It was also noted that the Department's new claims processing currently being implemented will capture payment information from the MCOs.
- As providers adopt and implement electronic health records and connect to Maryland's Health Information Exchange, quality of care will improve. Providers will be able to receive alerts on their patients and exchange clinical data. This integration will occur regardless of the model selected.
- Option 1 allows information to be shared through a single source, which will reduce administrative and clinical complexity for individuals who transition between Medicaid and the new Health Benefit Exchange.

Other Comments

- To gain an understanding of how to yield better treatment among the Medicaid population the Department should consider specific data that drives treatment
- As the Department moves forward with this process, it should identify the sub populations that account for large percentages of expenditures and select a model that would best target those consumers.

WORKGROUP CHARGE 2: PERFORMANCE MEASURES

The second charge of the workgroup was to develop performance measures to evaluate the integrated system. The workgroup assumed that development of performance measures would be independent of what model was selected. The Executive Sponsor initiated this effort by presenting current systems of measuring performance in HealthChoice, the ADAA grant system, and MHA's ASO contract (see Appendix 6). This gave participants an opportunity to view the current system of performance management and helped foster discussion on how to structure performance measurement under an integrated system. At the request of participants, the Executive Sponsor presented a proposed framework for performance measures (see Appendix 7).

Comments on Performance Measurement Framework

Workgroup participants submitted a variety of comments on the proposed framework. We attempted to capture participants' comments below; this is an illustrative rather than an exhaustive list, and it may not represent the views of every participant.

- Federal initiatives will drive performance and reporting requirements. It was noted, however, that the State should also drive its own reform efforts;
- A measure of patient satisfaction ought to be included;
- Clinical outcomes should be included under the framework's consumer experience category;
- When developing the overall performance management system, MHA's Outcomes Management System (OMS) ought to be used as a reference;
- A measure of provider workforce development ought to be included in the performance measurement system;
- Participants cited concerns about outdated provider information. A measure should be included that encourages providers to update contact information and update status regarding acceptance of new patients;
- Performance management should include monitoring of denial rates for substance abuse and mental health services. Some participants commented that it would be helpful to see current MCO and ASO denial rates by procedure. Another commenter responded that this information should be viewed with caution because comparing denial rates between mental health and substance abuse services may not be an apples-to-apples comparison;
- Incentives should be included in the performance management system, and they should be aligned across administrative entities as well as triggered by performance; and,
- Incremental incentives should be built into the evaluation measures.

GENERAL COMMENTS ON MODEL CHOICE

In addition to providing feedback related to the workgroup's charge, participants offered general comments on the models. Several participants expressed support for Model 2 (BHO carve out), citing its advantage by addressing provider challenges with MCOs. Some participants supported a Model "2b" (performance-based carve out), noting the complications of establishing a capitation payment for behavioral health services. Other participants noted that Model 3 (population carve-out) would create churning among health plans. Participants noted the risk that once an individual enters the behavioral health MCO, the individual would remain in the MCO despite being "cured." A non-consumer member noted that Model 3 might cause individuals with a behavioral health diagnosis to feel stigmatized. Certain participants noted that changing how substance abuse services are delivered at this juncture would certainly disrupt the impressive grains made over the last couple of years. Lastly, a participant noted that Model 2 would allow the flexibility of services and coordination required across child-and family-serving systems. While other participants noted that Option 1 is the only model which achieves full integration of somatic health care, mental health care, and addiction care.

Participating Organizations

The Data and Evaluation workgroup included representation from the following organizations.

1. Anne Arundel County Mental Health Agency
2. Alliance, Inc.
3. Amerigroup
4. Baltimore Crisis Response, Inc.
5. Baltimore Mental Health Systems
6. Baltimore Substance Abuse Systems (BSAS)
7. Catholic Charities
8. Chase Brexton Health Services
9. Community Behavioral Health Association Of Maryland (CBH)
10. Consumer
11. Core Service Agency - Charles County Department of Health
12. Delmarva Foundation for Medical Care (DFMC)
13. Department of Budget and Management (DBM)
14. Department of Legislative Services
15. DHMH - Money Follows the Person (MFP)
16. Glass Health
17. Harris Jones & Malone, LLC
18. Health Management Consultants, LLC
19. HealthCare Access MD
20. The Hilltop Institute at UMBC
21. Johns Hopkins Bayview Medical Center
22. Howard County Health Department
23. Institutes for Behavior Resources Inc, Reach Mobile Health Services
24. Johns Hopkins HealthCare
25. Johns Hopkins University
26. Maryland Addictions Directors Council (MADC)
27. Maryland Association of Core Service Agencies (MACSA)
28. Maryland Department of Disabilities
29. Maryland Disability Law Center (MDLC)
30. Maryland Physicians Care
31. Maryland Psychiatric Society (MPS)
32. Medstar Health
33. Mental Health Association of Maryland (MHAMD)
34. Mental Hygiene Administration
35. MHNET Behavioral Health
36. Mosaic Community Services
37. Mountain Manor
38. National Alliance on Mental Illness of Maryland
39. On Our Own of Maryland, Inc.
40. PDG Rehabilitation Services
41. People Encouraging People, Inc.
42. Public Policy Partners
43. Riverside Health
44. The Children's Guild
45. The Institute for Innovation and Implementation
46. University of Maryland Law School - Drug Policy Clinic
47. University of Maryland System Evaluation Center
48. Value Options